

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2011
NAME OF PROVIDER OR SUPPLIER WOODVIEW ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3320 E STATE BLVD FORT WAYNE, IN 46805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>An Environmental Preoccupancy Survey for State Licensure of a Residential facility for the addition of 1 bed in room 300 was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 11/10/11</p> <p>Facility Number: 012107 Provider Number: 012107 AIM Number: NA</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Environmental Preoccupancy survey, Woodview Assisted Living was found in compliance with 410 IAC, 16.2-5-1.5, Sanitation and Safety Standards, and 16.2-5-1.6, Physical Plant Standards of the Indiana Health Facilities Rules for Residential care facilities.</p> <p>This two story building of Type V (111) construction was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and resident sleeping rooms. The facility has a capacity of 107 and a census of 89 at the time of this survey.</p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 11/17/11.</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1